STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007136	A. BUILDING: _____ B. WING _____	06/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVING CARE AGENCY INC	2647 WATERFRONT PKWY E DR STE 150 INDIANAPOLIS, IN 46214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments This visit was a Home Health state complaint investigation survey. Complaint #IN00128986 - Substantiated: No deficiencies related to the allegation are cited. Survey Dates: June 17-19 , 2013 Facility Number: 007136 Medicaid #: 200869820 Surveyors: Kelly Ennis, BSN, RN, Public Health Nurse Surveyor Eric Moran, BSN, RN, Public Health Nurse Surveyor Quality Review: Joyce Elder, MSN, BSN, RN June 24, 2013	N 000		